Bureau of Health Care Quality and Compliance

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED - 04/14/2011	
				A. BUILDING B. WING			
			B. WING				
NAME OF PROVIDER OR SUPPLIER STREET ADD				RESS, CITY, STA	ATE, ZIP CODE		
CARSON	VALLEY RESIDENTIAL	CARE CENTER		ERLING RD /ILLE, NV 894	410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ECTIVE ACTION SHOULD BE COMPLE ENCED TO THE APPROPRIATE DATE	
Y 000	0 Initial Comments			Y 000			
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 4/14/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 84 Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was 69. Fifteen resident files were reviewed and 15 employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of A. The following deficiencies were identified:		Y 255				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				B. WING		04/	14/2011	
NAME OF PF	ROVIDER OR SUPPLIER	•	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	1		
CARSON	VALLEY RESIDENTIAL (CARE CENTER		ERLING RD /ILLE, NV 89	410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
Y 255	Y 255 Continued From page 1 This Regulation is not met as evidenced by: Based on observation, interview and record review on 4/14/11, the facility failed to ensure the kitchen complied with the standards of NAC 446.			Y 255				
	Findings include:							
	1. Critical Violations:							
	a. A staff member entered the kitchen without washing their hands and proceeded to dispense ice from the ice machine.							
	2. Cleaning and Sanitation Issues:							
	a. Two white kitchen cutting boards were found excessively stained from overuse.		und					
		utting board had exces ris on the underside of t						
	c. The plastic kitcher bottom.	n blender was cracked	at the					
	d. The backside of the condenser had dust to							
	e. Heavily soiled single use sponges were observed in the dishwashing area.							
f. Single use 'cottage cheese and margarine' containers were being re-used for other food storage.								

AND PLAN OF CORRECTION IDENTIFICATION NU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				A. BUILDING	<u> </u>	OOWII EETEB	
		NVN105AGC		B. WING		04/14/2011	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	I RESS, CITY, STA	ATE, ZIP CODE	<u> </u>	72011
				ERLING RD			
CARSON	VALLEY RESIDENTIAL	CARE CENTER	GARDNER\	/ILLE, NV 89	410		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FUI			PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR		COMPLETE DATE
TAG	REGULATORY OR	EGO IDEIVIII TIIVO IIVI ORIMAT	1011)	TAG	DEFICIENCY)	OTRIATE	
Y 255	Continued From page	0.2		Y 255			
1 255	Continued From pag	6 2		1 233			
		manly atomad in the					
	g. A mop was impro dishwashing area.	g. A mop was improperly stored in the					
	distiwasining area.						
	Severity: 2 Scope: 3	3					
\/ 050				\/ 050			
Y 859 SS=D		Physical examination of	a	Y 859			
00 2	resident						
	NAC 449.274						
	5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by						
		esident must be cared functions provided by the	or				
	resident's physician.	deliens provided by the					
	Toolson to project the						
	This Regulation is not met as evidenced by: Based on interviews and record review conducted on 4/14/11, the facility failed to ensure 1 of 15						
		residents received an annual physical examination. (Resident #4).					
	Severity: 2 Scope: 1						
V 074				V 074			
Y 871 SS=C	NAC 449.2742(1)(d)((1-8)(1)(e) Medication F	rian	Y 871			
	NAC 449.2742						
		tain a plan for managin	g the				
	administration of medications at the						
	residential facility, inc	cluding, without limitatio	n:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN105AGC		(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED 04/14/2011	
				B. WING	·	04		
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CARSON VALLEY RESIDENTIAL CARE CENTER			1189 KIMM	ERLING RD VILLE, NV 894				
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Y 871	1 Continued From page 3			Y 871				
	SUMMARY STATEMENT OF DEFICIENCIES X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)							

AND PLAN OF CORRECTION IDENTIFICATION NO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						00 2.		
		NVN105AGC		B. WING		04/	14/2011	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	04/	14/2011	
				ERLING RD	·			
CARSON	VALLEY RESIDENTIAL	CARE CENTER		VILLE, NV 89	410			
(X4) ID	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLETE	
PREFIX TAG				PREFIX TAG	CROSS-REFERENCED TO T	THE APPROPRIATE	DATE	
Y 871	Continued From pag	e 4		Y 871				
	the plan. The admini	n annual training updat strator shall maintain erning the provision of t I the attendance of						
	Based on record rev the administrator fail	s Regulation is not met as evidenced by: ed on record review and interview on 4/14/11, administrator failed to prepare a medication that included all eight components.						
	Severity: 1 Scope: 3							